# ND RYAN WHITE PROGRAM PART B ENROLLMENT APPLICATION

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
SFN 54191 (02-2018)

The following information is requested to determine if you qualify for the North Dakota Ryan White Program Part B. The law does not require that you provide the information. However, without this information, we may be unable to determine your eligibility for assistance, or help you with appropriate referrals.

It is against the law for you to provide information that is not true. If you do, you may be charged with a crime.

All the information you provide is private and confidential. Only those people who need the information to do their jobs will see your information. These people are the North Dakota Ryan White Program Part B staff; program auditors, private health insurance plans, your medical care providers, the county financial worker, your case manager, and any advocate you may list on this application. We will ask your permission for anyone else to see the information you give us.

Items you will need to provide:

☐ **Identity/Age**: Bring records that prove the identity and age of household member applying for assistance (birth certificate, driver's license, etc.).

☐ **Expenses**: Bring current records for the following expenses to help us determine services for which you may be eligible:

- Medical Expenses
- Health insurance premium statement
- Utility/shelter payments:

☐ Rent ☐ Heating/cooling costs ☐ Other utility bills

☐ **Income**: Bring records to show your gross/net income (most recent tax form, wage stubs, SSDI, SSI, etc.).

☐ **Health insurance**: Bring explanation of benefits and the insurance card. If uninsured bring a denial letter or record of an exemption.

☐ **Medicaid/Medicare**: Bring a denial or acceptance letter if your income is below 200 percent of the Federal Poverty Level (FPL).

☐ **Residence**: Bring records to show where you live (rent receipts, utility bills, etc.). You must be able to produce a state ID within 60 days of applying.

When you fill out this application:

- Answer all questions to the best of your knowledge.
- Sign and date where indicated.
- Return this form to your case manager or to:

Ryan White Program Part B
North Dakota Department of Health
Division of Disease Control
2635 East Main Avenue
Bismarck, ND 58506-5520
Fax: (701) 328-0338
Telephone: (701) 328-2378

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| ND Ryan White Case Management Site | ND Ryan White Client Number | ND ADAP Client Number |
|---|---|---|
| | | |

## Applicant's Information

| Name of Applicant | | Social Security Number | | |
|---|---|---|---|---|
| Street Address | | City | State | ZIP Code |
| Mailing Address (if different) | | City | State | ZIP Code |
| Primary Telephone Number | Secondary Telephone Number | | Email Address | |
| Date of Birth | Country of Birth | | Primary Language | |

Gender
☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Transgender Other

Risk Category (please select all that apply):
☐ Men having sex with men (MSM) ☐ Heterosexual contact ☐ Injection drug use (IDU)
☐ Hemophilia/coagulation disorder ☐ Perinatal (mother to child) ☐ Organ transplant or blood transfusion
☐ Work related exposure ☐ Unknown ☐ Other_____

Race (check all that apply)
☐ Asian ☐ American Indian ☐ Black/African American ☐ Pacific Islander ☐ White

Hispanic or Latino:
☐ Yes ☐ No

| Physician's Name | Clinic | Pharmacy |
|---|---|---|
| Emergency Contact's Name | Phone Number | Relationship |

Citizenship Status
☐ Citizen ☐ National ☐ Permanent Resident ☐ Temporary Visa ☐ Undocumented

Employment Status
☐ Employed full-time ☐ Employed part-time ☐ Unemployed ☐ Disabled ☐ Retired

## Assistance Requested

☐ Case management (all clients eligible)
☐ Health care (medical, dental) payment assistance
☐ Other: _____
☐ AIDS Drug Assistance Program (ADAP)
☐ Housing assistance and supportive services

## Insurance Information

Select all the policies that you have and attach a copy of the front and back of the card.

☐ Medicaid (Traditional) ☐ Medicaid expansion
☐ Medicare Part A/B ☐ Medicare Part D ☐ Medicare supplemental
☐ Private employer ☐ Private individual ☐ VA, other military ☐ IHS
☐ Other (specify): _____

Policy Carrier:_____ Policy Number:_____ Start Date: _____
Policy Carrier:_____ Policy Number:_____ Start Date: _____

☐ **No Insurance***
*If uninsured, please briefly explain why you are not enrolled in, or do not qualify, for health coverage.

_____

## Household Characteristics

| Household Type (check one) | Housing Type (check one) |
|---|---|
| ☐ Live alone<br>☐ Live with husband, wife, partner<br>☐ Live with child or children<br>☐ Live with mother, father, or other family members<br>☐ Other (please specify): | ☐ Permanent housing (apartment, house, boarding house)<br>☐ Temporary (transitional housing for homeless, staying with friends or family)<br>☐ Unstable (emergency shelter, jail, vehicle, streets, hotel or motel paid for by the emergency funding) |

How many persons living with you are related to you by blood, marriage, or adoption: _____

How many members of the household are below the age of 18: _____

Describe current living arrangement (stability, safety, affordability).

_____

_____

_____

## Household Gross (Before Taxes) Income

List information about income for all household members related to the client by blood, marriage or adoption.

| Name | Relationship | Birth Date | Type of Income | Monthly Gross Income |
|---|---|---|---|---|
| | Self | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | Total Monthly Income: | |

## Statement of No Income

If you currently have no income, please fill out the following information.

☐ I did not file income tax in 20_____. This statement is true to the best of my knowledge.

☐ I currently have no income and have not received income since_____

Please explain how your living expenses are met if you report no current income.

_____

_____

## Service Needs Assessment

**Income Management**

☐ Housing, please specify _____

_____

☐ Utilities
☐ Food
☐ Clothing
☐ Paying bills/money management
☐ Other (please specify) _____

_____

**Personal Needs**

☐ Finding/keeping a job
☐ Child care
☐ Transportation
☐ Other (please specify) _____

_____

**Health Care**

☐ Medical
- ☐ Outpatient medical care
- ☐ Vision
- ☐ Dental
- ☐ Prescriptions
- ☐ Insurance Premium

☐ Mental health concerns
☐ Abuse concerns
- ☐ Alcohol
- ☐ Street/Prescription Drugs
- ☐ Tobacco
- ☐ Physical
- ☐ Emotional

☐ Other (please specify) _____

_____

_____

## Recommended Screenings and Immunizations Assessment

### Tobacco Screening

| | | | |
|---|---|---|---|
| Are you a tobacco user? | ☐ Yes | ☐ No | ☐ Former User |
| Are you interested in quitting at this time? | ☐ Yes | ☐ No | |
| Are you exposed to second-hand smoke? | ☐ Yes | ☐ No | |
| Referral offered: | ☐ Yes | ☐ No | |

### Recommended Screenings for HIV Positive Persons (please fill out to the best of your knowledge)

Have you been screened for *Tuberculosis (TB)* since HIV diagnosis? ☐ Yes, date tested:_____ ☐ No

Have you been screened for *Hepatitis B* since HIV diagnosis? ☐ Yes, date tested:_____ ☐ No
Have you been screened for *Hepatitis C* since HIV diagnosis? ☐ Yes, date tested:_____ ☐ No

Have you been screened for *syphilis* in the past 12 months?
☐ Yes, date tested:_____ ☐ No ☐ Not medically indicated (not sexually active)

Have you been screened for *chlamydia and gonorrhea* in the past 12 months?
☐ Yes, date tested:_____ ☐ No ☐ Not medically indicated (not sexually active)

Are you currently pregnant?
☐ Yes, estimated delivery date: _____ ☐ No ☐ Not applicable

Have you received cervical cancer screening (Pap smear) in the past 12 months?
☐ Yes, date_____ ☐ No ☐ Not applicable

**To be Completed by Case Manager**

### Recommended Adult Vaccinations

Please select which of the following recommended vaccines the client has received. Please use NDIIS or request an immunization record for the missing doses. If there is no documentation of doses, patient is considered not vaccinated.

☐ *Hepatitis A* vaccine series (2 doses)
☐ *Hepatitis B* vaccine series (3 doses)
☐ *Influenza (flu)* vaccine in the past 12 months
☐ *Meningococcal conjugate* vaccine (MenACWY) (2 doses)
☐ *Pneumococcal* vaccine (PCV13 or Prevnar 13®)
☐ *Pneumococcal* vaccine (PPSV23 or Pneumovax®) in the past five years
☐ *Tdap (tetanus, diphtheria, and pertussis)* vaccine or a booster in the last ten years

Has the client completed the *human papilloma virus (HPV)* vaccine series (2-3 doses) if you are less than 26 years of age (male or female)?
☐ Yes, date:_____ ☐ No ☐ Not applicable

Has the client received the *Pneumocystis pneumonia (PCP)* prophylaxis if their CD4 count was below 200 cells/mL in the past 12 months?
☐ Yes, date:_____ ☐ No ☐ Not medically indicated ☐ Refused

Vaccines recommended for healthy adults with **CD4 T-cell count above 200 cells/mL only.**

| | | | |
|---|---|---|---|
| *MMR (measles, mumps, and rubella)* vaccine series (2 doses)? | ☐ Yes | ☐ No | |
| Have you received the *zoster (shingles)* vaccine if you are 60 years and older? | ☐ Yes | ☐ No | ☐ Not applicable |
| Have you received the *varicella (chickenpox)* vaccine (2 doses)? | ☐ Yes | ☐ No | ☐ Not applicable |

### Prescription Medication

What medications is the client currently taking for the treatment of HIV infection?

_____

_____

Please select whether you provided screening and counseling for the following:

| | | | |
|---|---|---|---|
| HIV transmission risk | ☐ Yes | ☐ No | ☐ Not medically indicated |
| Mental Health Screening | ☐ Yes | ☐ No | ☐ Not medically indicated |
| Substance Abuse Screening | ☐ Yes | ☐ No | ☐ Not medically indicated |

## ND Ryan White Program Part B Certificate of Eligibility

The client's and case manager's signatures below certify that the following eligibility criteria for ND Ryan White Program reimbursement have been met:

☐ North Dakota Proof of Residency provided (i.e., rent receipts, utility or phone bills) and within 60 days a state issued ID.

☐ Income Eligibility Criteria Met. Annual income limitations: less than, or equal to, 400 percent of the Federal Poverty Level (FPL), or **$48,560** for 2018 for a single individual.

**2018 HHS Poverty Guidelines**

| Size of Family Unit | 100 Percent of Poverty | 138 Percent of Poverty | 400 Percent of Poverty |
|---|---|---|---|
| 1 | $12,140 | $16,753 | $48,560 |
| 2 | $16,460 | $22,715 | $65,840 |
| 3 | $20,780 | $28,676 | $83,120 |
| 4 | $25,100 | $34,638 | $100,400 |

☐ Application for Medicaid/Medicare or other programs have been completed (if applicable). (If the applications have been denied, the denial letters must be on file with the case manager.)

☐ Proof of income (most recent tax return, two weeks of paystubs, SSI/SSDI statement) are attached.

☐ A copy of all insurance policies (front and back) is attached.

☐ Release of Information form signed.

### Certification

I hereby certify that the representation of my income, insurance and other financial assistance is a true and accurate statement and that eligibility requirements as listed above have been met and documented. I also certify that any increases in income, insurance or other financial assistance will immediately be reported to my case manager. I understand re-enrollment on an annual basis is required. I understand that I must **re-enroll each year by April 30,** and **recertify by October 31.** If I fail to do so, I will become ineligible to receive services through the ND Ryan White Program.

I have received a copy of my responsibilities as a North Dakota Ryan White client and I agree to all terms.
☐ Yes ☐ No

☐ I am interested in participating on a ND Ryan White Advisory Board as a consumer-advisor about issues related to my status and care (optional).

Client/Guardian Signature _____ Date _____

Case Manager Signature _____ Date _____

**ND RYAN WHITE PROGRAM PART B CLIENT RIGHTS AND RESPONSIBILITIES**
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
(02-2018)

As a participant in the ND Ryan White Program Part B, you have the right to:

- Be treated with respect, dignity, consideration, and compassion.
- Receive case management services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical and/or mental ability.
- Participate in creating a plan for case management services.
- Be informed about services and options available to you.
- Reach an agreement with your case manager about the frequency of contact you will have, either in person or over the telephone.
- Have your medical records and case management records be treated confidentially.
- Have information released only in the following circumstances:
    - When you sign a written release of information.
    - When there is a medical emergency.
    - When a clear and immediate danger to you or others exists.
    - When there is possible child or elder abuse.
    - When ordered by a court of law.
- File a grievance about services you are receiving or denial of services.
- Not be subjected to physical, sexual, verbal and/or emotional abuse or threats.

As a participant in the North Dakota Ryan White Program Part B, you have the responsibility to:

- Treat other clients and staff of this agency with respect and courtesy.
- Protect the confidentiality of other clients you may encounter at this agency.
- Not subject case managers, staff, or other clients to physical, sexual, verbal and/or emotional abuse or threats.
- Participate as much as you are able in creating a plan for case management.
- Let your case manager know any concerns you have about your case management plan or changes in your needs.
- Make and keep appointments to the best of your ability, or if possible to phone to cancel or change an appointment time.
- Stay in communication with your case manager by informing him/her of changes in your address or phone number, income, and responding to the case manager's calls or letters to the best of your ability.
- Provide your case manager any requests for payment of bills within 30 days of the statement date. Bills given to case managers after 30 days will not be covered.
- Apply for all programs your case manager asks of you to ensure ND Ryan White Program Part B is the "payer of last resort."
- File taxes and provide your case manager with the tax returns.
- Stay in care by visiting your doctor regularly and take prescribed medication to ensure your health and well-being.
- Every six months re-certify your eligibility and enrollment in the ND Ryan White Program Part B. **Failure to re-enroll by April 30 or re-certify by October 31 will jeopardize continued assistance with health care and medication expenses.**

I understand the above information, and I have received a copy for my records.

Client/Guardian Signature _____ Date _____

Case Manager Signature _____ Date _____